

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

350

62-009960
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

FILED APR 2 1962

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Length of stay in 1b <u>50 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph State Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>419 Isadore</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lester Franklin Holtsclaw</u>		4. DATE OF DEATH Month Day Year <u>March 22 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1884</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days Hours Mins. <u>2 4 10 35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western-Wyeth Hardware</u>	
11. BIRTHPLACE (City and state or country) <u>Missouri; Bolchow</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>Martin Holtsclaw</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Withrow</u>	
14. NAME OF HUSBAND OR WIFE <u>Olga Holtsclaw</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk. No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Hospital Records, St. Joseph, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3-10-62</u> to <u>3-22-62</u> and last saw him alive on <u>3-22-62</u> Death occurred at <u>10:35 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>G. S. Waraich M.D.</u>	
22b. ADDRESS <u>State Hospital, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>3-22-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 26, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 24, 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF CERTIFICATION
G. S. Waraich M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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APR 10 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond H. Hooy

Licensed Embalmer No. 5147

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.